IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

June 10, 2009

Tom Whittemore
Communicare, Inc #3 Pond
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #3 Pond, provider #13G010

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure and complaint survey of Communicare, Inc #3 Pond, which was conducted on June 4, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 23, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by June 23, 2009. If a request for informal dispute resolution is received after June 23, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G010	A. BUILDING _____ B. WING _____	06/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNICARE, INC #3 POND	2650 SOUTH POND BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your annual recertification survey. The survey was conducted by: Jim Troutfetter, QMRP, Team Leader Sherri Case, QMRP Common abbreviations/symbols used in this report are: IPP - Individual Program Plan QMRP - Qualified Mental Retardation Professional	W 000	RECEIVED JUN 25 2009 FACILITY STANDARDS	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on review of behavior incident reports, record review, and staff interview it was determined the facility failed to ensure parents and legal guardians were notified of events, per their requests. This failure directly impacted 2 of 6 individuals (Individuals #1 and #2) whose guardian notification sheets were reviewed and had the potential to effect 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This resulted in the potential lack of advocacy for individuals by their legal guardians. The findings include: 1. Individual #1's IPP, dated 10/23/08,	W 148	W148 Corrective Actions: We have a notification system which generally works well. In analyzing this citation we have decided to have the QMRP at this location reprocess notification requests to insure we have current and accurate information. We will then update our notification/contact list and insure all on-call administrative staff are aware of this information. Administrator/Designee assigned staff will additionally be re-inserviced as to any change in this contact information. The QMRP will continue to document family contacts in the QMRP Log; the Administrator/Designee will continue to document notification of client-to-client contact and injury in the Administrator Notification Log; nurses will continue to document any family	6-23-2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrative 6-23-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 148	Continued From page 1 documented a 56 year old male diagnosed with severe mental retardation, and mood disorder, not otherwise specified. The "Notification Request" for Individual #1, dated 9/6/06, documented his guardian requested to be notified of any client to client assaults involving Individual #1. Behavior Incident Reports reviewed from 12/08 - 5/09, documented Individual #3 pushed Individual #1 on 12/15/08 and 2/19/09. Individual #3 hit Individual #1 in the back on 3/20/09 and hit him with a ball on 1/7/09. The reports did not include documentation that Individual #1's guardian had been contacted. When asked if the guardian was notified, the QMRP stated during an interview on 6/4/09 at 10:15 a.m., she would follow up. As of 6/8/09, no further documentation was received by the state agency. 2. Individual #2's IPP, dated 10/2/08, documented a 34 year old male diagnosed with moderate mental retardation, attention deficit hyperactivity disorder, and bipolar disorder. The "Notification Request" for Individual #2, dated 9/6/06, documented his parents requested to be notified of any accident with an injury. Accident Reports reviewed from 12/08 - 5/09, documented Individual #2 had scratches on his back from a fall that occurred on 3/4/09. The report did not include documentation that Individual #2's parents were notified. When asked if the guardian was notified, the	W 148	contact in the Medical Observation Log; and the QMRP will continue to be responsible for noting who made family contact on the back of the combination Accident/Injury & Behavior Incident Report (A/I & BIR). Identifying Others Potentially Affected: All persons living at this location are potentially affected. System Changes: See corrective action. In addition, since the RN Supervisor is now closely monitoring the combination A/I & BIR system in her monthly review process she will also check the family notification area which QMRPs are to fill out and report any missed documentation to the QMRP Supervisor for further corrective action. Monitoring: See System Changes. In addition, as part of the administrator notification process our Administrative team reviews these verbal reports at routinely scheduled Monday morning meetings. We will continue to discuss issues of family/guardian notification for individuals who have been involved either in client-to-client contact or who have been injured and, starting 06/23/09, will remind QMRPs that documentation of contacts is to be made on the combination A/I & BIR.	

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W 148	Continued From page 2 QMRP stated during an interview on 6/4/09 at 10:15 a.m., she would follow up. As of 6/8/09, no further documentation was received by the state agency. The facility failed to ensure the parents/guardians for Individuals #1 and #2 were notified of significant events as they requested.	W 148		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #1's IPP, dated 10/23/08, documented a 56 year old male diagnosed with severe mental retardation, and mood disorder not otherwise specified. Individual #1's Behavior Management/Support	W 312	W312 Corrective Actions: All medication reduction plans were reprocessed at this location by the QMRP supervisor 03/09 and the issue noted was an error which has now been corrected (see attached). Identifying Others Potentially Affected: We do not believe others at this location are affected but will check for similar processing errors as BMPs and associated medication plans are revised. System Changes: We are now including the Medication Reduction Plan as Section I.A of the BMP to ensure that this information is reviewed/updated when changes are made to the BMP. We hope to make no further errors in this process. Monitoring: Since the QMRP Supervisor is responsible for these updates, we will continue to involve the QMRP as fact checker/editor.	6-19-2009

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W 312	Continued From page 3 Plan, dated 1/09, documented he received Abilify (an antipsychotic drug) and Gabitril (an anticonvulsant drug) for treatment of intermittent explosive disorder. However, the Reduction Criteria section of his Psychoactive Medication Reduction Plan, dated 2/20/09, included a criteria for reducing food stealing. When asked during an interview on 6/4/09 from 9:55 - 10:55 a.m., the QMRP Supervisor stated the criteria for food stealing should be taken out of the medication reduction plan as it was not related to intermittent explosive disorder. The facility failed to ensure Individual #1's Medication Reduction Plan included clear and accurate information.	W 312		

Bureau of Facility Standards

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MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197		
MM237	16.03.11.080.03(g) Unusual Occurence To be notified promptly in the event of any unusual occurrence, including serious illness or accident, impending death, or death; and in the case of death, to be told of autopsy findings if an autopsy is performed; and This Rule is not met as evidenced by: Refer to W148.	MM237	RECEIVED JUN 25 2009 FACILITY STANDARDS	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. The findings include: 1. An environmental review was conducted at the facility on 6/2/09 from 2:40 - 3:00 p.m. At that time, the following toxic chemicals were noted to be unlocked in a storage cabinet in the garage: - One 1 gallon container of paint. - One 1 quart container of paint. - One container of liquid carpet cleaner. Additionally, there was a one gallon container of	MM271	MM 271 The chemicals had been placed in an unlocked cabinet in error. Upon discovery, the items were placed into a locked cabinet. We were not able to identify why the items were placed in an unsecure cabinet, therefore we will in-service all staff members as to the proper locked storage location at the staff meeting scheduled for June 16, 2009. The AQ will check from time to time but at least monthly to further assure all chemicals are properly stored. The day treatment Center was in its second day of operation after a fire and the related repairs were completed. The door to the supply	6-16-2009

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MM271	Continued From page 1 bleach located in an unlocked cabinet to the left of the kitchen sink. 2. Individuals #1 and #3 attended the facilities day treatment center. During an observation at the center on 6/2/09 from 11:10 a.m. - 12:11 p.m., a storage closet was noted to be open. The closet contained the following chemicals: - Morning Mist disinfectant with a label stating "May be fatal if absorbed through the skin." and "Causes irreversible eye damage and skin burns." - One 1 gallon container of bleach. - 4 spray cans of Citrus Splash with a warning label stating it was flammable and to avoid contact with eyes and skin. - 8 spray cans of glass cleaner. - 5 one gallon containers of Sundance floor cleaner with a label stating it was an eye irritant. During an interview on 6/2/09 at 11:56 a.m., the Assistant QMRP stated the door could not be closed and that maintenance had been notified. When asked during an interview on 6/4/09 from 9:55 - 10:55 a.m., the QMRP Supervisor stated the door should have been fixed so the door could be closed and locked. The facility failed to ensure all toxic chemicals were stored under lock and key.	MM271	room had not been closed as supplies were being purchased and placed into the room. It is our policy to securely lock supplies which might be harmful. In this instance it was found went an attempt to close the door failed, that the new carpet strip prevented the door from closing. Our maintenance man completed the necessary repair before the end of the day on which the problem was noted. In keeping with our policy the door is locked when clients are in the building.	

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June 10, 2009

Tom Whittemore
Communicare, Inc #3 Pond
40 West Franklin Road, Suite F
Meridian, ID 83642

Provider #13G010

Dear Mr. Whittemore:

On **June 4, 2009**, a complaint survey was conducted at Communicare, Inc #3 Pond. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004109

Allegation #1: Individuals are not protected from assaults by other individuals.

Findings: An unannounced on-site complaint investigation was conducted from 6/1/09 through 6/4/09. During that time, review of individuals' records, observations, and interviews with facility staff were completed with the following results:

Observations were conducted in the afternoon on 6/1/09 and in the morning on 6/2/09. During that time, an individual was noted to push another individual, however, direct staff were noted to intervene by stepping between the two individuals.

No less than 5 direct care staff were interviewed and reported individuals did not target a specific individual. Direct care staff stated one individual usually targeted staff but if another individual was close he would hit the individual. All direct care staff stated they were to step between the two individuals to protect them.

Individuals' records were reviewed for appropriate corrective action to maladaptive behavior. No concerns were identified.

Therefore, while individual to individual assaults did occur, the facility intervened and took appropriate corrective action to prevent re-occurrence. Due to the lack of sufficient evidence, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Parents guardians are not notified of significant events as requested.

Findings: An unannounced onsite complaint investigation was conducted from 6/1/09 to 6/4/09. During that time observations, interviews and record reviews were conducted with the following results:

Guardian/family Notification requests for 6 individuals were reviewed. One of the individuals' guardian/family requested to be notified of any client to client assaults involving the individual she represented.

Behavior Incident Reports reviewed from 12/08 - 5/09, documented the individual she represented was pushed by another individual on 12/15/08, and 2/19/09. The same individual hit him with a ball on 1/7/09 and hit him on the back on 3/20/09. The reports did not include documentation the family member had been contacted.

When asked if the guardian was notified, the QMRP stated during an interview on 6/4/09 at 10:15 a.m., she would follow up. As of 6/8/09, no further documentation was received by the state agency.

The "Notification Request" for another individual documented his parents had requested to be notified of any accident with an injury.

Accident Reports reviewed from 12/08 - 5/09, documented the individual had scratches on his back from a fall. The report did not include documentation the parents had been notified.

When asked if the parents were notified, the QMRP stated during an interview on 6/4/09 at 10:15 a.m., she would follow up. As of 6/8/09, no further documentation was received by the state agency.

The facility failed to ensure individuals' parents/legal guardians were notified of significant events as requested. Therefore, the allegation was substantiated and the facility's deficient practice was cited at W148.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

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